FOR OHF USE

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027680

Facility Name: SHERIDAN HEALTH CARE CENTER

Address: 2534 ELIM AVENUE (Number) ZION (City) 60099 (Zip Code)

County: LAKE

Telephone Number: (847) 746-8435 **Fax #** (847) 746-1744

IDPA ID Number: 363194993001

Date of Initial License for Current Owners: 10/10/82

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) GARRY S. CHANKIN, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	96	Skilled (SNF)	96	35,040	1
2		Skilled Pediatric (SNF/PED)			2
3	192	Intermediate (ICF)	192	70,080	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	288	TOTALS	288	105,120	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	513		3,109	3,622	8
9	SNF/PED					9
10	ICF	66,244	4,061	3,612	73,917	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,757	4,061	6,721	77,539	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.76%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
ADULT DAY CARE AND MEALS ON WHEELS

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/1/82

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/82 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 2939

Medicare Intermediary ADMINASTAR FEDERAL, INC.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	299,386	56,954	9,074	365,414		365,414		365,414			1
2	Food Purchase		396,737		396,737		396,737	(207)	396,530			2
3	Housekeeping	322,391	59,044		381,435		381,435		381,435			3
4	Laundry	190,176	72,050	4,376	266,602		266,602		266,602			4
5	Heat and Other Utilities			203,297	203,297		203,297		203,297			5
6	Maintenance	204,644	15,459	105,722	325,825		325,825	(14,908)	310,917			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,016,597	600,244	322,469	1,939,310		1,939,310	(15,115)	1,924,195			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	2,525,225	172,819	20,131	2,718,175		2,718,175	(5,606)	2,712,569			10
10a	Therapy	88,542	6,810	4,618	99,970		99,970		99,970			10a
11	Activities	90,479	21,795	3,432	115,706		115,706		115,706			11
12	Social Services	412,922	2,297	8,323	423,542		423,542		423,542			12
13	Nurse Aide Training	17,363	942	500	18,805		18,805		18,805			13
14	Program Transportation			3,566	3,566		3,566		3,566			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,134,531	204,663	46,570	3,385,764		3,385,764	(5,606)	3,380,158			16
	C. General Administration											
17	Administrative	154,098		484,000	638,098		638,098	(352,230)	285,868			17
18	Directors Fees											18
19	Professional Services			83,011	83,011		83,011	(500)	82,511			19
20	Dues, Fees, Subscriptions & Promotions			125,069	125,069		125,069	(59,430)	65,639			20
21	Clerical & General Office Expenses	164,109	8,551	175,156	347,816		347,816	(59,432)	288,384			21
22	Employee Benefits & Payroll Taxes			624,467	624,467		624,467	(1,991)	622,476			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,929	5,929		5,929	(2,430)	3,499			24
25	Other Admin. Staff Transportation			1,101	1,101		1,101	(336)	765			25
26	Insurance-Prop.Liab.Malpractice			90,232	90,232		90,232		90,232			26
27	Other (specify):*							6,242	6,242			27
28	**TOTAL General Administration**	318,207	8,551	1,588,965	1,915,723		1,915,723	(470,107)	1,445,616			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,469,335	813,458	1,958,004	7,240,797		7,240,797	(490,828)	6,749,969			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER #0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			298,278	298,278		298,278	1,696	299,974			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			283,847	283,847		283,847	(82,902)	200,945			32
33	Real Estate Taxes			170,370	170,370		170,370		170,370			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			40,267	40,267		40,267		40,267			35
36	Other (specify):*			8,497	8,497		8,497	(8,497)				36
37	TOTAL Ownership			801,259	801,259		801,259	(89,703)	711,556			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		197,892	242,936	440,828		440,828		440,828			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			7,956	7,956		7,956	(7,903)	53			41
42	Provider Participation Fee			158,076	158,076		158,076	(396)	157,680			42
43	Other (specify):*	80,576		5,298	85,874		85,874	(85,874)				43
44	TOTAL Special Cost Centers	80,576	197,892	414,266	692,734		692,734	(94,173)	598,561			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,549,911	1,011,350	3,173,529	8,734,790		8,734,790	(674,705)	8,060,085			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,696	30		9
10	Interest and Other Investment Income	(82,902)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(207)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(14,670)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(24,449)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(208,184)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (328,717)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(345,988)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (345,988)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (674,705)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

SHERIDAN HEALTH CARE CENTER

ID# 0027680

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VETERANS PHYSICIAN EXPENSE	$ (2,755)	10	1
2	BAD DEBTS	(42,501)	21	2
3	ALZHEIMERS CONSULTANT	(4,882)	43	3
4	DIRECTOR - ADULT DAY CARE	(62,825)	43	4
5	DAY PROGRAM EXPENSE	(188)	43	5
6	PARTNERS LIFE INSURANCE	(1,991)	22	6
7	AMORTIZATION EXPENSE	(8,497)	36	7
8	VETERANS LAB EXPENSE	(2,851)	10	8
9	VENDING INCOME	(7,903)	41	9
10	PPA - BAD DEBTS	(15,668)	21	10
11	CAPITALIZED R&M	(14,908)	06	11
12	2002 SEMINAR EXPENSE	(580)	24	12
13	MARKETING CONSULTANT	(1,000)	21	13
14	NONALLOWABLE LEGAL	(500)	19	14
15	COPE DUES - JCLTC	(6,218)	20	15
16	YELLOW PAGE ADVERTISING	(14,093)	20	16
17	PROVIDER LICENSE	(396)	42	17
18	COST - ADULT DAY CARE	(228)	43	18
19	C.N.A. ADULT DAY CARE	(17,751)	43	19
20	NONALLOWABLE TRAVEL	(336)	25	20
21	PENALTIES	(263)	21	21
22	2001 SEMINAR FROM PRIOR YEAR COST REP	150	24	22
23	PRIOR YEAR SEMINAR EXPENSE	(2,000)	24	23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90				90
91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(207)											(207)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(14,908)											(14,908)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(15,115)											(15,115)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(5,606)											(5,606)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(5,606)											(5,606)	16
	C. General Administration													
17	Administrative			(146,582)	17,004	(97,866)	(124,786)						(352,230)	17
18	Directors Fees													18
19	Professional Services	(500)											(500)	19
20	Fees, Subscriptions & Promotions	(59,430)											(59,430)	20
21	Clerical & General Office Expenses	(59,432)											(59,432)	21
22	Employee Benefits & Payroll Taxes	(1,991)											(1,991)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(2,430)											(2,430)	24
25	Other Admin. Staff Transportation	(336)											(336)	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			3,611		2,394	237						6,242	27
28	**TOTAL General Administration**	(124,119)		(142,971)	17,004	(95,472)	(124,549)						(470,107)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(144,840)		(142,971)	17,004	(95,472)	(124,549)						(490,828)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	1,696											1,696	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(82,902)											(82,902)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(8,497)											(8,497)	36
37	**TOTAL Ownership**	(89,703)											(89,703)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(7,903)											(7,903)	41
42	Provider Participation Fee	(396)											(396)	42
43	Other (specify):*	(85,874)											(85,874)	43
44	**TOTAL Special Cost Centers**	(94,173)											(94,173)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(328,717)		(142,971)	17,004	(95,472)	(124,549)						(674,705)	45

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - STAN ARON	$	PRO HEALTH CARE, INC.	100.00%	$ 97,490	$ 97,490	15
16	V	27	PAYROLL TAXES				3,611	3,611	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V	17	MNGMNT. FEES - PRO HEALTH	148,072				(148,072)	23
24	V	17	MNGMNT. FEES - PRO HEALTH	96,000				(96,000)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 244,072			$ 101,101	$ * (142,971)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$	SHA, LTD.	100.00%	$	$	15
16	V	17	MANAGEMENT FEES	388,000				(388,000)	16
17	V	17	M. FEES - FINN CONS.				128,466	128,466	17
18	V	17	M. FEES - PRO HEALTH				148,072	148,072	18
19	V	17	M. FEES - SHABAT & ASSOC.				128,466	128,466	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 388,000			$ 405,004	$ * 17,004	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - J. FINN	$	FINN CONSULTING, INC.	100.00%	$ 30,600	$ 30,600	15
16	V	27	PAYROLL TAXES				2,394	2,394	16
17	V								17
18	V	17	MANAGEMENT FEES	128,466				(128,466)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 128,466			$ 32,994	$ * (95,472)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - RON SHABAT	$	SHABAT & ASSOCIATES	100.00%	$ 3,680	$ 3,680	15
16	V	27	PAYROLL TAXES				237	237	16
17	V								17
18	V	17	MANAGEMENT FEES	128,466				(128,466)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 128,466			$ 3,917	$ * (124,549)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	STANTON ARON	PARTNER	MANAGEMENT	16.31%	SEE ATTACHED	22	33.85%	Alloc-Pro H	$ 97,490	17-7	1
2	JACK FINN	PARTNER	MGMT. CONS.	9.32%	SEE ATTACHED	17	48.57%	Finn Consult	30,600	17-7	2
3	RONALD SHABAT	PARTNER	MGMT. CONS.	16.67%	SEE ATTACHED	2	3.64%	Shabat & Assoc	3,680	17-7	3
4	NANJEAN PAINTER	PARTNER	MANAGEMENT	1.75%	SEE ATTACHED	40	80.00%	Salary	136,211	12-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 267,981		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PRO HEALTH CARE, INC. C/O FR&R
Street Address: 111 PFINGSTEN ROAD
City / State / Zip Code: DEERFIELD, IL 60115
Phone Number: (847)236-1111
Fax Number: (847)236-1155

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - STAN ARON	Average Hours Wkd	51	4	$ 226,000	$ 226,000	22	$ 97,490	1
2	27	PAYROLL TAXES	Average Hours Wkd	51	4	8,372		22	3,611	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 234,372	$ 226,000		$ 101,101	25

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SHA, LTD. C/O FR&R
Street Address: 111 PFINGSTEN ROAD
City / State / Zip Code: DEERFIELD, IL 60115
Phone Number: ((847)236-1111
Fax Number: ((847)236-1155

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	M. FEES - FINN CONS.	Direct Allocation	1	1	128,466		1	128,466	1
2	17	M. FEES - PRO HEALTH	Direct Allocation	1	1	148,072		1	148,072	2
3	17	M. FEES - SHABAT & ASSOC.	Direct Allocation	1	1	128,466		1	128,466	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 405,004	$		$ 405,004	25

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FINN CONSULTING INC.
Street Address: 2901 W. COYLE
City / State / Zip Code: CHICAGO, IL 60645
Phone Number: ((773)764-3466
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - J. FINN	Average Hours Wkd	35	2	$ 63,000	$ 63,000	17	30,600	1
2	27	PAYROLL TAXES	Average Hours Wkd	35	2	4,930		17	2,394	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 67,930	$ 63,000		$ 32,994	25

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SHABAT & ASSOCIATES
Street Address: 7514 N. SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: ((847)982-1195
Fax Number: ((847)982-0992

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - RON SHABAT	Average Hours Wkd	55	11	101,200	101,200	2	3,680	1
2	27	PAYROLL TAXES	Average Hours Wkd	55	11	6,506		2	237	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 107,706	$ 101,200		$ 3,917	25

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	MANUFACTURERS BANK		X	MORTGAGE	$46,648	9/28/98	$ 4,500,000	$ 3,655,769	9/08	7.04%	$ 270,309	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MANUFACTURERS BANK		X	LINE OF CREDIT	VARIES	7/10/94	1,700,000	271,000	7/10/95	5.00%	13,538	6
7												7
8												8
9	TOTAL Facility Related				$46,648		$ 6,200,000	$ 3,926,769			$ 283,847	9
	B. Non-Facility Related*											
10	See Supplemental Schedule											10
11	INTEREST INCOME		X								(82,902)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (82,902)	14
15	TOTALS (line 9+line14)						$ 6,200,000	$ 3,926,769			$ 200,945	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	157,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	160,170	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,370	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	168,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	170,370	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	139,248	8
	1997	146,705	9
	1998	146,210	10
	1999	150,301	11
	2000	160,170	12

2001 ACCRUAL = 160170 * 1.05 = 168000

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SHERIDAN HEALTH CARE CENTER COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0027680

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-22-301-009	Long Tern Care Property	$ 6,577.94	$ 6,577.94
2.	04-22-301-007	Long Tern Care Property	$ 153,592.10	$ 153,592.10
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 160,170.04	$ 160,170.04

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 4

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

ADUL.T DAY CARE - 860 SQUARE FEET

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	50,091	1990	$ 28,460	1
2					2
3	TOTALS	50,091		$ 28,460	3

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1990	$ 5,384,307	$	35	$ 153,837	$ 153,837	$ 1,833,224	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1980	5,655		20	-		5,655	9
10	Various			1981	13,906		20	-		13,906	10
11	Various			1982	1,171		20	-		1,171	11
12	Various			1983	17,000		20	-		16,819	12
13	Various			1984	36,737		20	-		36,737	13
14	Various			1985	135,882		20	5,984	5,984	119,258	14
15	Various			1986	63,852		20	3,361	3,361	52,096	15
16	Various			1987	60,439		20	3,021	3,021	44,026	16
17	Various			1988	24,257		20	1,212	1,212	16,362	17
18	Various			1989	102,083		20	5,420	5,420	78,775	18
19	Various			1990	84,998		20	4,250	4,250	50,147	19
20	Various			1991	10,496		20	526	526	5,676	20
21	Various			1992	18,109		20	889	889	8,598	21
22	Various			1993	39,981		20	1,999	1,999	17,341	22
23	Various			1994	123,996		20	6,203	6,203	47,026	23
24	Various			1995	157,007		20	7,851	7,851	53,168	24
25	Various			1996	210,423		20	10,523	10,523	56,639	25
26	Various			1997	97,938		20	4,898	4,898	22,491	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		-	-		-		-	68
69	Financial Statement Depreciation			298,278			(298,278)		69
70	TOTAL (lines 4 thru 69)		$ 6,588,237	$ 298,278		$ 209,974	$ (88,304)	$ 2,479,115	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,588,237	$ 298,278		$ 209,974	$ (88,304)	$ 2,479,115	1
2	HOT WATER HEATER	1998	6,200		20	310	310	1,214	2
3	REPLACE SHOWER VALVE	1998	5,220		20	261	261	1,022	3
4	CERAMIC FLOORING	1998	7,587		20	379	379	1,516	4
5	DOOR REPLACEMENTS	1998	6,100		20	305	305	1,144	5
6	FIRE DOORS	1998	1,275		20	64	64	235	6
7	WALLPAPER	1998	1,079		20	54	54	194	7
8	WALLPAPER	1998	2,594		20	130	130	466	8
9	WALLPAPER	1998	3,674		20	184	184	659	9
10	CERAMIC FLOORING	1998	(720)		20	(36)	(36)	(129)	10
11	WALL PANELS	1998	576		20	29	29	104	11
12	WALL PANELING	1998	806		20	40	40	143	12
13	HOT WATER HEATER	1998	1,089		20	54	54	198	13
14	EXHAUST FAN/AIR HOOD	1998	5,433		20	272	272	975	14
15	MAIN LOBBY IMPROVEMT	1998	7,845		20	392	392	1,372	15
16	TILES	1998	779		20	39	39	137	16
17	CONCRETE	1998	1,700		20	85	85	290	17
18	WALL PANELING	1998	576		20	29	29	99	18
19	PIPE INSTALLATION	1998	1,057		20	53	53	181	19
20	SHOWER RM DOOR/FRAME	1998	845		20	42	42	154	20
21	CEILING LIGHTS	1998	848		20	42	42	140	21
22	SECURITY BUZZER/SENS	1998	630		20	32	32	104	22
23	SWING DOOR CONTROL	1998	764		20	38	38	124	23
24	ELEVATOR FLOORS	1998	682		20	34	34	108	24
25	WALLPAPER	1998	716		20	36	36	114	25
26	WALLPAPER	1998	507		20	25	25	77	26
27	PNEUMATIC SYS RPRS	1998	5,225		20	261	261	848	27
28	PNEUMATIC SYS RPRS	1998	1,020		20	51	51	162	28
29	AIR HANDLER RPR	1998	3,754		20	188	188	595	29
30	AIR COMPRESSOR RPR	1998	1,985		20	99	99	314	30
31	CARPETING	1998	795		20	40	40	127	31
32	STEEL DOOR	1998	874		20	44	44	139	32
33	WALLPAPER	1998	640		20	32	32	99	33
34	TOTAL (lines 1 thru 33)		$ 6,660,392	$ 298,278		$ 213,582	$ (84,696)	$ 2,492,040	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,660,392	$ 298,278		$ 213,582	$ (84,696)	$ 2,492,040	1
2	LIGHT FIXTURES/TILES	1998	890		20	45	45	139	2
3	CARPET	1998	354		20	18	18	56	3
4	SIGN	1998	3,859		20	193	193	595	4
5	CERAMIC FLOORING	1998	(720)		20	(36)	(36)	(129)	5
6	CERAMIC FLOORING	1998			20				6
7	DINING RM RENOVATION	1999	700		20	35	35	96	7
8	DINING RM RENOVATION	1999	5,000		20	250	250	688	8
9	SOUTH FENCE	1999	2,445		20	122	122	336	9
10	PENTHOUSE - LTC	1999	26,615		20	1,331	1,331	3,660	10
11	INSULATED GLASS	1999	525		20	26	26	78	11
12	PUMP MOTOR	1999	3,855		20	193	193	579	12
13	INFRARED DOOR	1999	3,200		20	160	160	467	13
14	WATER HEATER	1999	12,792		20	640	640	1,813	14
15	FENCING	1999	2,845		20	142	142	414	15
16	BORDERS	1999	2,336		20	117	117	341	16
17	CARPETING	1999	1,943		20	97	97	259	17
18	COVE BASE	1999	576		20	29	29	77	18
19	FLOOR TILES	1999	4,691		20	235	235	627	19
20	VINYL FLOOR	1999	2,752		20	138	138	368	20
21	HANDRAILS	1999	1,042		20	52	52	134	21
22	REPLACE PIPING	1999	2,787		20	139	139	382	22
23	FREEZER REPAIR	1999	2,297		20	115	115	316	23
24	PENTHSE/LOB HVAC RPR	1999	12,511		20	626	626	1,617	24
25	INSULATE PIPES	1999	1,875		20	94	94	251	25
26	COUNTER SEAT	1999	1,242		20	62	62	160	26
27	VCT INSTALLATIO	1999	5,483		20	274	274	708	27
28	WALLPAPER	1999	3,374		20	169	169	437	28
29	WALLPAPER	1999	691		20	35	35	90	29
30	CORNER GUARD	1999	58		20	3	3	8	30
31	FLOOR TILES	1999	60		20	3	3	8	31
32	CORNER GUARD	1999	58		20	3	3	8	32
33	FLOORING	1999	10,690		20	535	535	1,338	33
34	TOTAL (lines 1 thru 33)		$ 6,777,218	$ 298,278		$ 219,427	$ (78,851)	$ 2,507,961	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,777,218	$ 298,278		$ 219,427	$ (78,851)	$ 2,507,961	1
2	PENTHOUSE - JJ'S	1999	25,000		20	1,250	1,250	3,333	2
3	HVAC REPAIRS	1999	4,116		20	206	206	549	3
4	RENOVATION - JJ'S	1999	15,000		20	750	750	1,875	4
5	RUBBER TILE	1999	402		20	20	20	48	5
6	BUMPER/HANDRAIL	1999	517		20	26	26	63	6
7	BORDERS	1999	405		20	20	20	48	7
8	THE GLASS CUTTER	1999	2,659		20	133	133	344	8
9	KOSCO FLAGS & POLES	1999	1,664		20	83	83	194	9
10	BASE/FLOOR PATCHING	1999	1,008		20	50	50	117	10
11	REMODEL STORAGE ROOM	1999	4,000		20	200	200	483	11
12	DOORS	1999	489		20	24	24	58	12
13	PENTHOUSE - JJ'S	1999	5,000		20	250	250	604	13
14	RENOVATION - LTC	1999	30,000		20	1,500	1,500	3,625	14
15	HEATER VENTS	1999	535		20	27	27	65	15
16	REMODEL STORAGE RM	1999	10,000		20	500	500	1,208	16
17	HANDRAILS	1999	824		20	41	41	96	17
18	CAR PORT REPAIRS	1999	2,250		20	113	113	264	18
19	DINING ROOM RENOVATI	1999	(2,150)		20	(108)	(108)	(288)	19
20	REMODEL STORAGE ROOM	1999	4,300		20	215	215	502	20
21	FIRE DOOR	1999	3,719		20	186	186	419	21
22	FLOOR TILES	1999	302		20	15	15	34	22
23	DRYWALL	1999	2,629		20	131	131	317	23
24	SHOWER ROOM REPAIRS	1999	750		20	38	38	86	24
25	PENTHOUSE - JJ'S	1999	4,160		20	208	208	468	25
26	PATCH HOLES	1999	1,168		20	58	58	121	26
27	ROLLER SHADES	1999	2,148		20	107	107	232	27
28	FIRE DOOR	1999	3,719		20	186	186	419	28
29	ARCHITECT'S FEES	1999	7,860		20	393	393	393	29
30	FIRE DOOR 4TH FLR SO	2000	4,038		20	202	202	404	30
31	FIRE DOOR 4THFLR NOR	2000	4,038		20	202	202	404	31
32	DOORS - BREAKROOM	2000	923		20	46	46	92	32
33	DOWN PAYMENT - WALLS	2000	5,550		20	278	278	533	33
34	TOTAL (lines 1 thru 33)		$ 6,924,241	$ 298,278		$ 226,777	$ (71,501)	$ 2,525,071	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,924,241	$ 298,278		$ 226,777	$ (71,501)	$ 2,525,071	1
2	DAYCARE CTR ARCHITEC	2000	787		20	39	39	75	2
3	ARCHITECT FEES	2000	6,140		20	307	307	614	3
4	ARCHITECT - DEMENTIA	2000	752		20	38	38	73	4
5	GLASS ALUM DOOR	2000	800		20	40	40	77	5
6	ELECTRICAL WORK	2000	1,440		20	72	72	144	6
7	WINDOW/LIGHT FIXTURE	2000	3,980		20	199	199	365	7
8	MAIN DINING RM 4THFL	2000	5,630		20	282	282	541	8
9	ARCHITECT - DEMENTIA	2000	269		20	13	13	25	9
10	CHAIR RAILING	2000	1,884		20	94	94	165	10
11	HANDRAILS	2000	1,453		20	73	73	134	11
12	ELECTRICAL SOCKETS	2000	1,826		20	91	91	159	12
13	DOORS - REHAB DEPT	2000	600		20	30	30	53	13
14	DOORS	2000	2,704		20	135	135	225	14
15	WALLPAPER	2000	824		20	41	41	65	15
16	WALLPAPER	2000	1,826		20	91	91	152	16
17	PIPING	2000	4,552		20	228	228	380	17
18	INSTALL FAUCETS	2000	3,925		20	196	196	310	18
19	WALLPAPER	2000	1,988		20	99	99	157	19
20	CORNER GUARDS	2000	652		20	33	33	52	20
21	WALLCOVERING	2000	153		20	8	8	12	21
22	WALLPAPER	2000	1,000		20	50	50	75	22
23	WALLGUARD	2000	883		20	44	44	66	23
24	FIRE DOOR	2000	4,130		20	207	207	293	24
25	WALLPAPER	2000	666		20	33	33	47	25
26	WALLCOVERING	2000	632		20	32	32	48	26
27	TRAC LIGHTING	2000	671		20	34	34	48	27
28	WINDOW TREATMENTS	2000	618		20	31	31	41	28
29	METAL DOOR	2000	1,010		20	51	51	68	29
30	CARPET	2000	1,354		20	68	68	91	30
31	SHADES	2000	2,666		20	133	133	177	31
32	FIRE DOOR	2000	4,137		20	207	207	259	32
33	WALL GUARD	2000	636		20	32	32	40	33
34	TOTAL (lines 1 thru 33)		$ 6,984,829	$ 298,278		$ 229,808	$ (68,470)	$ 2,530,102	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 6,984,829	$ 298,278		$ 229,808	$ (68,470)	$ 2,530,102	1
2	HINGE/LOCK/DEADBOLT	2000	656		20	33	33	39	2
3	TILE	2000	703		20	35	35	35	3
4	ARCHITECT'S FEE	2000	573		20	29	29	29	4
5	MOTOR	2000	1,288		20	64	64	64	5
6	GENERATOR CIRCUIT	2000	1,159		20	58	58	58	6
7	COMPRESSOR CONTROLS	2000	2,448		20	122	122	122	7
8	TEMPERATURE CONTROLS	2000	2,666		20	133	133	133	8
9	HOT WATER BOILER	2000	602		20	30	30	30	9
10	CHILLER	2000	7,414		20	371	371	371	10
11	ALLEY LIGHTS	2000	504		20	25	25	25	11
12	3RD FLR CORNICES	2000	598		20				12
13	CUBICLE CURTAINS	2000	1,950		20	98	98	131	13
14	FIRE DOOR & INSTALL	2001	4,000		20	200	200	200	14
15	DOOR REPLACEMENT	2001	5,425		20	248	248	248	15
16	CORNICES & VALANCES	2001	2,455		20	123	123	123	16
17	WINDOW TREATMENT	2001	2,162		20	99	99	99	17
18	WALLCOVERING	2001	1,782		20	82	82	82	18
19	WALLCOVERING	2001	2,217		20	93	93	93	19
20	REMODELING	2001	8,000		20	300	300	300	20
21	FIRE PANEL	2001	605		20	23	23	23	21
22	REMODELING	2001	2,780		20	104	104	104	22
23	FIRE INSULATION	2001	546		20	18	18	18	23
24	ELECTRIC CIRCUIT	2001	230		20	8	8	8	24
25	REMODELING/DRYWALL	2001	3,286		20	137	137	137	25
26	FIRE DAMPERS	2001	9,779		20	326	326	326	26
27	BIRCH DOORS	2001	2,616		20	76	76	76	27
28	FLOORS	2001	1,883		20	55	55	55	28
29	WALLPAPER	2001	1,358		20	40	40	40	29
30	REFRIGERATION LINES	2001	10,203		20	298	298	298	30
31	WOODEN PLANTERS	2001	200		20	6	6	6	31
32	REFRIGERATION LINES	2001	10,204		20	298	298	298	32
33	PULL STATION PROTECT	2001	1,163		20	34	34	34	33
34	TOTAL (lines 1 thru 33)		$ 7,076,284	$ 298,278		$ 233,374	$ (64,904)	$ 2,533,707	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 7,076,284	$ 298,278		$ 233,374	$ (64,904)	$ 2,533,707	1
2	ROOM SIGN	2001	745		20	38	38	38	2
3	HANDRAIL	2001	1,955		20	49	49	49	3
4	ELECTRICAL CIRCUITS	2001	2,198		20	55	55	55	4
5	REFRIGERATION LINES	2001	4,689		20	117	117	117	5
6	FIRE DAMPER	2001	616		20	16	16	16	6
7	BOILER	2001	743		20	19	19	19	7
8	WALLPAPER	2001	4,243		20	71	71	71	8
9	RENOVATIONS	2001	1,900		20	24	24	24	9
10	MOSAIC/GROUT	2001	800		20	4	4	4	10
11	UPHOLSTED CORNICES	2001	769		20	10	10	10	11
12	CEMENT	2001	383		20	3	3	3	12
13	SOLAR SHADES	2001	4,028		20	67	67	67	13
14	ROOF INSULATION	2001	5,950		20	50	50	50	14
15	HANDRAIL/VINYL FLOOR	2001	6,519		20	27	27	27	15
16	WALLPAPER	2001	1,537		20	6	6	6	16
17	RECIPROCAL CHIILER	2001	4,576		20	19	19	19	17
18	CENTRAL AIR BLOWER	2001	1,192		20	45	45	45	18
19	FIRE DAMPERS	2001	9,103		20	341	341	341	19
20	PADDING	2001	908		20	19	19	19	20
21	APARTMENT COMPACTOR	2001	9,830		20	205	205	205	21
22	WALLPAPER	2001	2,905		20	60	60	60	22
23	FIRE DAMPERS	2001	2,133		20	107	107	107	23
24	COIL REPAIRS	2001	1,605		20	80	80	80	24
25	MOTOR	2001	705		20	35	35	35	25
26	LANDSCAPING	2001	925		20	46	46	46	26
27	COMPRESSOR REPAIRS	2001	4,255		20	213	213	213	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,151,496	$ 298,278		$ 235,100	$ (63,178)	$ 2,535,433	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 7,151,496	$ 298,278		$ 235,100	$ (63,178)	$ 2,535,433	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,151,496	$ 298,278		$ 235,100	$ (63,178)	$ 2,535,433	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 7,151,496	$ 298,278		$ 235,100	$ (63,178)	$ 2,535,433	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,151,496	$ 298,278		$ 235,100	$ (63,178)	$ 2,535,433	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 696,656	$	$ 57,167	$ 57,167	10	$ 399,669	71
72	Current Year Purchases	139,637		7,707	7,707	10	7,707	72
73	Fully Depreciated Assets	311,041				10	311,041	73
74								74
75	TOTALS	$ 1,147,334	$	$ 64,874	$ 64,874		$ 718,417	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,327,290	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 298,278	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 299,974	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,696	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,253,850	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	LAND - 1994	$ 199,000	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 199,000	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 25,895 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY VAN	DODGE VAN	$ 456	$ 5,467	17
18	ADMINISTRATIVE		685	8,905	18
19					19
20					20
21	TOTAL		$ 1,141	$ 14,372	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER AIDE	

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	157	785		942
3	Classroom Wages (a)		3,360		3,360
4	Clinical Wages (b)		3,360		3,360
5	In-House Trainer Wages (c)		10,643		10,643
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests	83	417		500
9	TOTALS	$ 240	$ 18,565	$	$ 18,805
10	SUM OF line 9, col. 1 and 2 (e)	$ 18,805			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	10
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	12

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 76,283	$		$ 76,283	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			6,453			6,453	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			70,042			70,042	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				195,837		195,837	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					90,158	2,055		92,213	13
14	TOTAL			$		$ 242,936	$ 197,892		$ 440,828	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 111,582	$	1
2	Cash-Patient Deposits	138,846		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,077,363		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,048,605		5
6	Prepaid Insurance	71,617		6
7	Other Prepaid Expenses	4,707		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	122,644		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,575,364	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	227,460		13
14	Buildings, at Historical Cost	5,384,307		14
15	Leasehold Improvements, at Historical Cost	1,609,331		15
16	Equipment, at Historical Cost	1,177,458		16
17	Accumulated Depreciation (book methods)	(3,435,369)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	57,356		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,020,543	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,595,907	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 338,573	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	177,503		28
29	Short-Term Notes Payable	271,000		29
30	Accrued Salaries Payable	211,114		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,068		31
32	Accrued Real Estate Taxes(Sch.IX-B)	168,000		32
33	Accrued Interest Payable	22,177		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	2,779		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,207,214	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,655,770		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,655,770	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,862,984	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,732,923	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,595,907	$	48

*(See instructions.)

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,521,755	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,521,755	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	725,967	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(514,799)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 211,168	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,732,923	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,701,832	1
2	Discounts and Allowances for all Levels	81,152	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,782,984	3
	B. Ancillary Revenue		
4	Day Care	51,366	4
5	Other Care for Outpatients		5
6	Therapy	329,528	6
7	Oxygen	20,249	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 401,143	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	11,838	11
12	Gift and Coffee Shop	7,903	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,393	19
20	Radiology and X-Ray		20
21	Other Medical Services	161,886	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 192,020	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	82,902	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 82,902	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	1,708	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,708	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,460,757	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,939,310	31
32	Health Care	3,385,764	32
33	General Administration	1,915,723	33
	B. Capital Expense		
34	Ownership	801,259	34
	C. Ancillary Expense		
35	Special Cost Centers	534,658	35
36	Provider Participation Fee	158,076	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,734,790	40
41	**Income before Income Taxes (line 30 minus line 40)****	725,967	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 725,967	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	856	947	$ 52,786	$ 55.74	1
2	Assistant Director of Nursing	2,194	2,519	107,385	42.63	2
3	Registered Nurses	17,578	19,736	594,474	30.12	3
4	Licensed Practical Nurses	25,961	27,948	595,273	21.30	4
5	Nurse Aides & Orderlies	126,498	134,100	1,116,807	8.33	5
6	Nurse Aide Trainees	800	800	17,363	21.70	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,711	8,716	88,542	10.16	8
9	Activity Director					9
10	Activity Assistants	6,999	7,562	90,479	11.96	10
11	Social Service Workers	21,435	23,621	412,922	17.48	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,828	32,760	299,386	9.14	15
16	Dishwashers					16
17	Maintenance Workers	16,941	18,638	204,644	10.98	17
18	Housekeepers	35,219	38,490	322,391	8.38	18
19	Laundry	16,565	18,501	190,176	10.28	19
20	Administrator	2,080	2,192	108,340	49.43	20
21	Assistant Administrator	2,080	2,128	45,758	21.50	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,241	3,875	164,109	42.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,447	4,862	58,500	12.03	31
32	Other Health Care(specify)					32
33	Other(specify)	3,624	3,909	80,576	20.61	33
34	TOTAL (lines 1 - 33)	325,057	351,304	$ 4,549,911 *	$ 12.95	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	monthly	$ 9,074	01-03	35
36	Medical Director	monthly	6,000	09-03	36
37	Medical Records Consultant	monthly	907	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	4,850	10-03	39
40	Physical Therapy Consultant	monthly	2,275	10a-03	40
41	Occupational Therapy Consultant	monthly	1,600	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	monthly	743	10a-03	43
44	Activity Consultant	monthly	3,432	11-03	44
45	Social Service Consultant	monthly	7,923	12-03	45
46	Other(specify)				46
47	URB Consultant	monthly	570	10-03	47
48	Specialized Services	monthly	400	12-03	48
49	TOTAL (lines 35 - 48)		$ 37,774		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	307	$ 13,804	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	307	$ 13,804		53

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARLA BENSON	ADMIN.		$ 108,340
ROSS ZELLER	ASST. ADMIN		45,758
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 154,098

B. Administrative - Other

Description	Amount
SHA, LTD - MANAGEMENT FEES	$ 388,000
PRO-HEALTH, ADMINISTRATIVE FEES	96,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 484,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	ACCOUNTING	$ 54,992
PAYCHEX	COMPUTER	10,978
SLS/ACCU-MED	COMPUTER	9,098
JOHN RYNLANDER	COMPUTER	253
R&D CONSULTING	COMPUTER	364
JACOBS HEALTHCARE	COMPUTER	2,175
GCS	COMPUTER	325
A-TECH	COMPUTER	1,337
PERSONNEL PLANNERS	UNEMPLOYMENT CONS.	1,725
AMR ENTERPRISES	WEB PAGE DESIGN	1,076
LANER, MUCHIN	LEGAL	188
FRANK RUFFNER MONT	LEGAL	500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 83,011

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 123,182
Unemployment Compensation Insurance	32,713
FICA Taxes	334,121
Employee Health Insurance	106,822
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS	25,638
TOTAL (agree to Schedule V, line 22, col.8)	$ 622,476

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	30,688
Health Care Worker Background Check	8,793
(Indicate # of checks performed 926)	
LICENSES	6,478
DUES - ICLTC	12,471
DUES AND SUBSCRIPTIONS	7,209
YELLOW PAGES ADVERTISING	14,093
PROMO ADVERTISING	24,449
Less: Public Relations Expense	
Non-allowable advertising	(24,449)
Yellow page advertising	(14,093)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 65,639

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	767
Seminar Expense	3,499
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,266

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC - $12,471.00**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **427** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **157,680**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%ln14**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees